COVID-19 Vaccine Consent Form -- Shawnee County, Kansas

Section 1: Information about person to RECEIVE vaccine (please print)

NAME (Last)	(First)	(M.I.)	DATE OF BIRTH month_____ day_____ year	
ADDRESS			AGE	GENDER
CITY	STATE	ZIP	PHONE NUMBER Home:_____ Work:_____	
Race/Ethnicity	Language		Primary Care Physician	

The following questions will determine if a person is eligible for the COVID-19 vaccine. Please mark YES or NO for each question.

A. If the answer is "YES" for one or more of the following questions in this section a health care provider will discuss your options.

	YES	NO
1. Is the person to be vaccinated sick today or running a fever?		
2. Does the person have a serious allergy to any vaccine components (mRNA, lipids (SM-102, polyethylene gycol [PEG] 2000 dimyristoyl glycerol [DMG], cholesterol, and 1,2-distearoyl-sn-glycero-3-phosphocoline [DSPC]), thromethamine, tromethamine hydrochloride, acetic acid, sodium acetate, and sucrose)?		
3. Does the person have any other known allergies? Please List_____		
4. Has the person ever had a serious reaction to a previous vaccine?		
5. Is the person to be vaccinated pregnant or planning to become pregnant?		

I acknowledge that I have been offered a copy of the Shawnee County Health Department's *NOTICE OF PRIVACY PRACTICES* with the effective date 10/18/17. I give consent to the Shawnee County Health Department for me or my child to receive the vaccination. I have been offered a copy of the current fact sheet for recipients and caregivers and understand the risks and benefits. I have read or have had explained to me and understand, the information in this fact sheet. I further authorize release of immunization records to any school, day-care center, health department, or other healthcare provider. A statement of charges for these services may be mailed to the above address. The Shawnee County Health Department may release my medical and financial information to my insurance provider, as necessary to receive payment. I understand I must make monthly payments and that no one is refused services due to inability to pay.

_____ _____

Patient or Responsible Party Signature **Date**

_____ _____

Print Name **Date of Birth**

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For Health Department Use Only

Date	Type of Vaccine	Route	Code	Lot #	Nurse Signature
	MODERNA Dose 1 Dose 2	Left Right Deltoid / Vas Lat	PUBLIC	011J20A	